

# ROSTER BILLING *Job Aid*

## Introduction

Roster billing was developed as a simplified process to providers to perform mass vaccination programs.

Properly licensed individuals and groups conducting mass immunization programs may submit claims using the roster billing format to bill for vaccines if they agree to accept assignment for these claims. Providers that utilize roster billing must accept assignment and may not collect any “donation” or other cost sharing of any kind from the Medicare beneficiaries for these immunizations.

## Provider Enrollment Criteria

Entities and individuals that want to provide mass immunization services but may not otherwise be able to qualify as a Medicare provider, may be eligible to enroll as a provider type “Mass Immunizer.” They must complete the CMS 855 form to enroll with the Medicare contractor. Once enrolled as a Mass Immunizer they must roster bill and accept assignment. No other services may be billed to Medicare by these providers except the vaccine(s) and their administrations. Visit our Provider Enrollment (<https://www.cgsmedicare.com/>) Web page for additional information.

## Completing the CMS 1500 and the Roster Form

Providers must complete a CMS-1500 claim form for each completed roster submitted. Only one vaccine may be submitted per claim and roster form.

**NOTE:** If other services were furnished to a beneficiary along with the vaccine, the provider must submit claims using normal billing procedures (filing the CMS-1500 or electronic billing for each patient).



Each of the following fields must be completed for roster billing:	
Item 1:	Place an "X" in the Medicare box
Item 2: (Patient's Name)	"See Attached Roster"
Item 11: (Insured's Policy Group or FECA Number)	"None"
Item 20: (Outside lab)	Place an "X" in the NO box
Item 21: (Diagnosis)	ICD-10 Z23 - Encounter for Immunization (Additional ICD-10 codes may apply.)
Item 24B (Place of Service)	Use the 2-digit place of service code "60" Note: POS code "60" must be used for roster billing
Item 24D: (Procedures, Services or Supplies)	Influenza Virus: Line 1 - <b>Appropriate influenza virus vaccine CPT or HCPCS code</b> Line 2 - <b>G0008</b> (administration of the flu vaccine) <b>OR</b> PPV: Line 1 - <b>Appropriate pneumococcal virus vaccine CPT or HCPCS code</b> Line 2 - <b>G0009</b> (administration of PPV)
Item 24E: (Diagnosis code pointer)	Lines 1 and 2: "1"
Item 24F: (\$ Charges)	<b>The provider must enter the charge for each listed service.</b> If the provider is not charging for the vaccine or its administration, they should enter <b>\$0.00</b> or <b>NC</b> (no charge) on the appropriate line for that item.
Item 27: (Accepting Assignment)	Place an "X" in the YES box.
Item 29: (Amount Paid)	"\$0.00"
Item 31: (Signature of Provider or Supplier)	The provider or a representative of the provider must sign.
Item 32: (Name and Address of the Facility)	Item 32 must be completed to report the name, address and ZIP code of the location where the service was provided.
Item 33: Provider's/ Supplier's Billing Name and Address)	Item 33 must be completed to report the name and address of the billing provider.
Item 33A: Provider's/ Supplier's NPI	The NPI of the billing provider should be reported in this field.

## Completing the Attached Roster Form

Qualified billers must attach a roster ([https://www.cgsmedicare.com/pdf/j15/j15\\_roster\\_billing\\_form.pdf](https://www.cgsmedicare.com/pdf/j15/j15_roster_billing_form.pdf)) that contains the claims information for supplier of the service and the individual beneficiaries. Provider's may make their own roster form, but at the minimum, the roster must contain:

- Provider name and NPI
- Control No. This is a CMS requirement for the form. Providers/Suppliers should NOT enter any information in this field.
- Date of service (Note: Although providers who provide immunizations may roster bill if they vaccinate fewer than five beneficiaries per day, they must include the individual date of service for each beneficiary's vaccination on the roster form.)
- Patient's Medicare MBI
- Patient's name
- Patient's address
- Date of birth
- Patient's gender (M or F)
- Beneficiary's signature or stamped "Signature on File"

**MAILING ADDRESS:** J15 — Part B/HHH Claims  
CGS Administrators, LLC  
PO Box 20019  
Nashville, TN 37202

The Centers for Medicare & Medicaid Services has a dedicated Web page for the influenza season. Visit the CMS website (<https://www.cms.gov/medicare/medicare-fee-for-service-part-b-drugs/mcrpartbdrugavgsalesprice/vaccinespricing>) to get the most up to date list of billing codes, effective dates, and payment allowances.

## Additional CMS Resources

- Roster Billing for Mass Immunizers: <https://www.cms.gov/roster-billing>
- Medicare Preventive Services Chart: <https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html>
- National Uniform Claim Committee (CMS-1500): <https://nucc.org/index.php/1500-claim-form-mainmenu-35>

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Sample CMS 1500 form shown at right, and at:

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500.pdf>



HEALTH INSURANCE CLAIM FORM										CARRIER		
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12												
PICA <input type="checkbox"/> PICA <input type="checkbox"/>												
1. MEDICARE <input checked="" type="checkbox"/> (Medicare) MEDICAID <input type="checkbox"/> (Medicaid) TRICARE <input type="checkbox"/> (TRICARE) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA (EMP) <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) See Attached Roster							
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER None a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO #yes, complete items 5, 9a, and 9d.							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits due to myself or to the party who accepts assignment below.) SIGNED DATE			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED DATE									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL			15. OTHER DATE MM DD YY QUAL		16. DATES PATENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. 17c. 17d. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-C to service line below (24B)) ICD-10 A. B. C. D. E. F. G. H. I. J. K. L.			22. RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLGF OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS UNITS	H. EMPD (NPI) #	I. ID. QUAL	J. RENDERING PROVIDER ID.#
1		Vaccine Code					1	1	NPI	111111111111		
2		Admin Code					1	1	NPI	111111111111		
3									NPI			
4									NPI			
5									NPI			
6									NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO		27. ACCEPT ASSIGNMENT? (For assignments, see 4041)		28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Refid for NUCC Use			
					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		0.00	0.00				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature of Auth Official			32. SERVICE FACILITY LOCATION INFORMATION Supplier/Provider Name Street Address City, ST ZIP		33. BILLING PROVIDER INFO & PH# Supplier/Provider Billing Name Billing Address City, ST ZIP		34. 111111111111					
SIGNED DATE			3. NPI b.		4. 111111111111 p.							
NUCC Instruction Manual available at: www.nucc.org										PLEASE PRINT OR TYPE	APPROVED OMB-0938-1197 FORM 1500 (02-12)	